

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-016677

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 179 Primary Registration District No. 5668 Registrar's No. 73

FILED MAY 8 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clark (Twp)</u>		Length of stay in 1b <u>2 wks.</u>	c. CITY OR TOWN <u>Whiteside Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wells Nursing Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Whiteside Mo.</u>		
3. NAME OF DECEASED (Type or print) First <u>LORA</u> Middle <u>ETHEL</u> Last <u>NICHOLS</u>			4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15 1890</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>Silex Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>George Cooper</u>		13b. MOTHER'S MAIDEN NAME <u>Sally Thompson</u>	
14. NAME OF HUSBAND OR WIFE <u>Thomas Nichols</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>None</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	
17. INFORMANT <u>Thomas Nichols</u>		18. CAUSE OF DEATH (Enter only one cause per part) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL DEGENERATION</u> ARTERIOSCLEROSIS CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>DIABETES - 2 YRS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS.</u> <u>5 YRS.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year _____		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Wentzville, Mo.</u>	
20g. COUNTY _____		20h. STATE _____		21. I attended the deceased from <u>JUNE 14, 1948</u> to <u>April 30 1963</u> and last saw her alive on <u>11/15/62</u> Death occurred at <u>11:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>WJ Bergesen</u>		(Degree or title) <u>D.O.</u>		22b. ADDRESS <u>WENTZVILLE, MO.</u>	
22c. DATE SIGNED <u>5/3/63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 3, 1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Corinth Cemetery</u>		23d. LOCATION (City, town, or county) <u>Foley Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Wayne McCoy Troy Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-7-1963</u>		26. REGISTRAR'S SIGNATURE <u>Charlotte Leck</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

Florida Board of Health
Department of Health
Bureau of Health Services
P.O. Box 1000
Tallahassee, Florida 32304

0700
0700

STATE OF FLORIDA
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES
P.O. BOX 1000
TALLAHASSEE, FLORIDA 32304

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

8-08
0-1

Student _____
Signature of Student Embalmer

Signed D.W. McCoy

Licensed Embalmer No. 3586

P. O. Address Troy, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.